STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING _____ B. WING _____	03/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN46617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for Investigation of Complaint IN00087056. Complaint IN00087056- Substantiated, Federal/State deficiencies related to the allegations are cited at F-157, F-225, F-226 and F-312. Unrelated deficiency cited Survey dates: March 7, 8, 9 and 10, 2011 Facility number: 000048 Provider number: 155115 AIM number: 100275330 Surveyor: Mary Anne Cilella, RN. Census bed type: SNF/NF: 117 Total: 117 Census payor type: Medicare: 14 Medicaid: 83 Other: 20 Total: 117 Sample: 6 Supplemental Sample: 9 These deficiencies also reflect state	F0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Desk Review in lieu of a Post Survey Review on or after April 7, 2011	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING _____ B. WING _____	03/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN46617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	findings cited in accordance with 410 IAC 16.2. Quality review completed on March 15, 2011 by Bev Faulkner, RN.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING _____ B. WING _____	03/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN46617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0157 SS=D	Based on interviews and record reviews, the facility failed to notify the physician and the resident's legal representative of diffuse bruising on the entire buttocks, thighs and around the breast area of 1 resident who was sent to the hospital when the bruising was identified in the sample of 6 reviewed for physician notification. Resident: B Findings include: Review on 3/8/11 at 4:00 p.m., of the hospital emergency department physician evaluation, dated 3/2/11, indicated Resident B was examined and had significant bruising, especially on the inside of her right thigh extending down to the right gluteal area. Bruising was also noted around her anus. No perineal bruising was observed. The resident also had a small hematoma on the left side of her forehead with some bruising. This report indicated the bruising appeared to be of varying duration suggesting minor trauma. Review of the closed clinical record of Resident B on 3/7/11 at 11:25 a.m., indicated the resident's diagnoses included, but were not limited to	F0157	F 157 It is the practice of this provider to immediately inform the resident, consult with the resident' s physician, and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status; a need to alter treatment significantly; or a decision to transfer or discharge the resident from the facility. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** · Resident # B: Resident's bruising was addressed with the physician on 3/2/11.· Licensed nurses were re-educated on the Change of Condition Policy and Procedure on 3/29/11. The Interdisciplinary Team continues to monitor the 24 Hour Report Sheet and Physician Order Forms for resident change of condition. The resident has experienced no negative outcome as a result of the alleged deficient practice. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** · Residents who experience a change of condition have the potential to be affected	04/07/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING _____ B. WING _____	03/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN46617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Parkinson's disease and dementia with psychosis. The resident resided in the secured unit prior to her transfer to the hospital. The admission Minimum Data Set (MDS) assessment, dated 2/11/11, indicated the resident had disorganized thinking patterns and exhibited physical and verbal symptoms towards others. The resident required extensive assistance with all activities of daily living and was able to ambulate with assistance from staff. The resident also utilized a walker. During interview on 3/9/11 at 2:45 p.m., with CNA#3, who gave the resident a shower on 3/1/11, the CNA indicated she notified LPN#1 of the new and fresh bruises to the resident's breast area and buttocks. The CNA indicated the nurse (LPN#1) proceeded to measure the areas. Review of the shower sheet for 3/1/11 indicated LPN#1 had documented "all bruises registered in tx (treatment) book on purple sheets." Review of the wound skin evaluation report (purple sheets) indicated multiple sheets with multiple bruising, but all the sheets were dated 2/27/11. No new measurements or description of new		by the alleged deficient practice. To ensure physicians are notified of a resident change of status: · Licensed nurses were re-educated to the facility Change of Condition Policy and Procedure on 3/29/11, by the Director of Nursing/Designee. · Noncompliance with facility policy and procedure may result in employee disciplinary action up to and including termination. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur** · Resident status change is placed on the “24 Hour Report Sheet” and the resident will have a documented assessment every shift for no less than 72 hours, if applicable, or until the resident’s condition stabilizes. · The “Physician Order” form is utilized for physician orders or changes in resident status that require a change in the resident’s plan of care. Notification of family and physician is recorded on this form. · The interdisciplinary team will review the “24 Hour Report” and “Physician Order” forms for physician and family notification at the Clinical morning meeting Monday thru Friday. The interdisciplinary team determines if any further interventions or changes to the plan of care is necessitated. The Unit Manager, or designee, will ensure	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING _____ B. WING _____	03/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN46617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	bruises were documented and it could not be determined the status of the bruising as reported in the hospital emergency department report. Nurses' notes lacked documentation the physician or the guardian had been notified of the bruising. During interview with the Administrator and the Director of Nursing on 3/08/11 at 11:00 a.m., they indicated the physician and the guardian had not been notified. The Administrator indicated LPN#1 felt it wasn't necessary since the responsible party was a guardian and not a member of the immediately family. This federal tag relates to Complaint IN00087056. 3.1-5(a)(2)		implementation. · The Nurse Manager-On-Call will be notified of acute resident change of status during non-business hours. The Nurse Manager-On-Call will notify the Director of Nursing Services and/or the Executive Director, as deemed necessary. · Charge nurses will review the Medication/Treatment Administration Records during shift report to ensure that medications/treatments are given and documented and that physicians are notified of a resident change of condition. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** · The physician orders and the 24 Hour Report sheets are reviewed by the Unit Managers and/or designee, to ensure resident change of condition is reported to the physician, physician orders are followed through timely, and care plans are updated. · A “Changer of Condition” CQI tool will be utilized weekly x 4, monthly x 2, and quarterly, thereafter, to monitor the Medication/Treatment Administration Records for compliance with administration, documentation, and physician notification, if applicable. The audits are reviewed by the CQI committee and action plans are developed, as needed, to improve	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING _____ B. WING _____	03/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN46617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			performance. **What is the date by which the systemic changes will be completed Compliance Date: April 7, 2011**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING _____ B. WING _____	03/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN46617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0225 SS=D	Based on interviews and record reviews, the facility failed to ensure injuries of unknown origin were reported immediately to the Administrator of the facility and other officials in accordance with state law through established procedures. This deficient practice related to 1 of 1 dependent residents in the sample of 6 who was found with diffuse bruising on the entire buttocks, thighs and around the breast area. Resident: B Findings include: Review on 3/8/11 at 4:00 p.m., of the hospital emergency department physician evaluation, dated 3/2/11, indicated Resident B was examined and had significant bruising, especially on the inside of her right thigh extending down to the right gluteal area. Bruising was also noted around her anus. No perineal bruising was observed. The resident also had a small hematoma on the left side of her forehead with some bruising. This report indicated the bruising appeared to be of varying duration suggesting minor trauma. Review of the closed clinical record of Resident B on 3/7/11 at 11:25 a.m.,	F0225	F 225 It is the practice of the provider to ensure that all alleged violations involving mistreatment, neglect, or abuse including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** · Resident B no longer resides in the facility. · Resident B's injury of unknown origin was reported to the appropriate agencies and administrator on 3/2/11. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** · Residents residing in the facility have the potential to be affected by the alleged deficient	04/07/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING _____ B. WING _____	03/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN46617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicated the resident's diagnoses included, but were not limited to Parkinson's disease and dementia with psychosis. The resident resided in the secured unit prior to her transfer to the hospital. The admission Minimum Data Set (MDS) assessment, dated 2/11/11, indicated the resident had disorganized thinking patterns and exhibited physical and verbal symptoms towards others. The resident required extensive assistance with all activities of daily living and was able to ambulate with assistance from staff. The resident also utilized a walker. Review of the nurses' notes from 2/18/11 to 3/2/11 indicated the following: 2/18/11 alert and confused, made several attempts to get out of bed. 2/19/11 restless , constantly getting up and trying to walk. physically aggressive, constantly moving. 2/20/11 restless, constantly getting up, poor safety awareness. 2/21/11 requires 1:1 care for safety awareness, constantly standing up and trying to get out of chair. 2/23/11 up and down, tries to walk and was tired within two minutes. 2/25/11 up during night, constantly rolling		practice. · A facility wide skin sweep was completed by the Licensed nurses on 3/3/11 to ensure no other skin alterations including bruises or other injuries. · Any identified concerns will be corrected as necessary and/or reported to administrator or designee and state agencies as indicated in the facility policy. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur** · Facility staff were re-educated on the Abuse Prohibition, Reporting and Investigation policy & procedure by the Ombudsman on March 23, 2011. · L.P.N. #1 is no longer employed at the facility. · Staff were re-educated regarding facility policy & procedure for investigation of injuries of unknown source. · Staff re-education regarding timely reporting of unusual occurrences or injuries of unknown origin to the Administration or designee and other state agencies. Emphasizing the importance of adhering to these policies & procedures. **How the corrective action(s) will be monitored to ensure the**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING _____ B. WING _____	03/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN46617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	herself on floor mat. 2/26/11 up at 2:30 a.m., unable to sit still. 2/27/11 up and down as usual 2/28/11 difficult to keep in bed, up within five minutes. When ambulating wants to sit down, just drops and staff has to catch her in the air or else she ended up on the floor. 3/1/11 1:1 care to ensure no falls. Edema noted in both feet. 3/2/11 restless, sat on the floor . Physician notified. Resident sent to the hospital for evaluation and subsequently admitted. Documentation was lacking in the nurses' notes to indicate any bruising was noted. During interview on 3/9/11 at 2:45 p.m., with CNA#3, who gave the resident a shower on 3/1/11, indicated she notified LPN#1 of the new and fresh bruises to the resident's breast area and buttocks. The CNA indicated the nurse (LPN#1) proceeded to measure the areas. Review of the shower sheet for 3/1/11 indicated LPN#1 had documented "all bruises registered in tx (treatment) book on purple sheets." Review of the wound skin evaluation report (purple sheets) indicated multiple sheets with multiple bruising, but all the sheets were dated 2/27/11. No new		**deficient practice will not recur, i.e., what quality assurance program will be put into place** · An "Abuse Prohibition and Investigation" CQI tool will be completed by the Director of Nursing/Designee Weekly X's 4 weeks, Monthly X's 2 months, and Quarterly thereafter. · Any identified trends or concerns will be addressed immediately. · Data will be submitted to the CQI committee for review and action plans initiated as needed. **What is the date by which the systemic changes will be completed** **Compliance Date: April 7, 2011**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING _____ B. WING _____	03/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN46617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	measurements or description of new bruises were documented and it could not be determined the status of the bruising as reported in the hospital emergency department report. During interview with Administrator and LPN#1 on 3/10/11 at 9:20 a.m., the LPN indicated she was the nurse in charge of the resident. She stated no one told her about the bruises around the breast area and thigh area. She didn't remember anything about measuring the areas. When the Administrator began questioning her about the CNA telling her about the newer, darker bruises, she remembered, but indicated she did not do anything about them because she thought they were already noted on the purple sheets. She indicated she should have updated the sheets and initialed new ones (purple sheets) for the fresh bruises. She further indicated she paged the supervisor once, but she wasn't in the facility yet and nothing more was done. The Administrator indicated neither she nor the Director of Nursing Service were aware of the extensive bruising until after the resident was sent to the hospital. This federal tag relates to Complaint IN00087056.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING _____ B. WING _____	03/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN46617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3.1-28(c)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING _____ B. WING _____	03/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN46617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0226 SS=D	Based on interviews and record reviews, the facility failed to ensure written policies and procedures that prohibit mistreatment, neglect and abuse of residents were implemented related to the reporting of extensive bruising of a suspicious nature and of unknown origin immediately to the Administrator of the facility and other officials in accordance with state law through established procedures. This deficient practice related to 1 of 1 residents in the sample of 6 who was found with extensive bruising of an unknown nature. Resident: B Findings include: Review on 3/8/11 at 4:00 p.m., of the hospital emergency department physician evaluation, dated 3/2/11, indicated Resident B was examined and had significant bruising, especially on the inside of her right thigh extending down to the right gluteal area. Bruising was also noted around her anus. No perineal bruising was observed. The resident also had a small hematoma on the left side of her forehead with some bruising. This report indicated the bruising appeared to be of varying duration suggesting minor trauma.	F0226	F 226 It is the practice of the provider to ensure that all alleged violations involving mistreatment, neglect, or abuse including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** · Resident B no longer resides in the facility. · Resident B's injury of unknown origin was reported to the appropriate agencies and administrator on 3/2/11. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** · Residents residing in the facility have the potential to be affected by the alleged deficient practice.	04/07/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING _____ B. WING _____	03/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN46617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Review of the closed clinical record of Resident B on 3/7/11 at 11:25 a.m., indicated the resident's diagnoses included, but were not limited to Parkinson's disease and dementia with psychosis. The resident resided in the secured unit prior to her transfer to the hospital. The admission Minimum Data Set (MDS) assessment, dated 2/11/11, indicated the resident had disorganized thinking patterns and exhibited physical and verbal symptoms towards others. The resident required extensive assistance with all activities of daily living and was able to ambulate with assistance from staff. The resident also utilized a walker. Review of the nurses' notes from 2/18/11 to 3/2/11 indicated the following: 2/18/11 alert and confused, made several attempts to get out of bed. 2/19/11 restless , constantly getting up and trying to walk. physically aggressive, constantly moving. 2/20/11 restless, constantly getting up, poor safety awareness. 2/21/11 requires 1:1 care for safety awareness, constantly standing up and trying to get out of chair.		· A facility wide skin sweep was completed by the Licensed nurses on 3/3/11 to ensure no other skin alterations including bruises or other injuries. · Any identified concerns will be corrected as necessary and/or reported to administrator or designee and state agencies as indicated in the facility policy. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur** · Facility staff were re-educated on the Abuse Prohibition, Reporting and Investigation policy & procedure by the Ombudsman on March 23, 2011. · L.P.N. #1 is no longer employed at the facility. · Staff re-education regarding facility policy & procedure for investigation of injuries of unknown source. · Staff re-education regarding timely reporting of unusual occurrences or injuries of unknown origin to the Administration or designee and other state agencies. Emphasizing the importance of adhering to these policies & procedures.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING _____ B. WING _____	03/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN46617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	2/23/11 up and down, tries to walk and was tired within two minutes. 2/25/11 up during night, constantly rolling herself on floor mat. 2/26/11 up at 2:30 a.m., unable to sit still. 2/27/11 up and down as usual 2/28/11 difficult to keep in bed, up within five minutes. When ambulating wants to sit down, just drops and staff has to catch her in the air or else she ended up on the floor. 3/1/11 1:1 care to ensure no falls. Edema noted in both feet. 3/2/11 restless, sat on the floor . Physician notified. Resident sent to the hospital for evaluation and subsequently admitted. Documentation was lacking in the nurses' notes to indicate any bruising was noted. During interview on 3/9/11 at 2:45 p.m., with CNA#3, who gave the resident a shower on 3/1/11, indicated she notified LPN#1 of the new and fresh bruises to the resident's breast area and buttocks. The CNA indicated the nurse (LPN#1) proceeded to measure the areas. Review of the shower sheet for 3/1/11 indicated LPN#1 had documented "all bruises registered in tx (treatment) book on purple sheets." Review of the wound skin evaluation		**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** · An "Abuse Prohibition and Investigation" CQI tool will be completed by the Director of Nursing/Designee Weekly X's 4 weeks, Monthly X's 2 months, and Quarterly thereafter. · Any identified trends or concerns will be addressed immediately. · Data will be submitted to the CQI committee for review and action plans initiated as needed. **What is the date by which the systemic changes will be completed** **Compliance Date: April 7, 2011**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING _____ B. WING _____	03/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN46617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	report (purple sheets) indicated multiple sheets with multiple bruising, but all the sheets were dated 2/27/11. No new measurements or description of new bruises were documented and it could not be determined the status of the bruising as reported in the hospital emergency department report. During interview with Administrator and LPN#1 on 3/10/11 at 9:20 a.m., the LPN indicated she was the nurse in charge of the resident. She stated no one told her about the bruises around the breast area and thigh area. She didn't remember anything about measuring the areas. When the Administrator began questioning her about the CNA telling her about the newer, darker bruises, she remembered, but indicated she did not do anything about them because she thought they were already noted on the purple sheets. She indicated she should have updated the sheets and initialed new ones (purple sheets) for the fresh bruises. She further indicated she paged the supervisor once, but she wasn't in the facility yet and nothing more was done. The Administrator indicated neither she nor the Director of Nursing Service were aware of the extensive bruising until after the resident was sent to the hospital.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING _____ B. WING _____	03/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN46617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Review of the undated facility policy entitled "Definition of Unusual Occurrence/Event" provided by the Administrator on 3/8/11, indicated "... Events that are required to be reported to the Director of Operations, DNS, Specialist and Director of Clinical Services and ISDH...injuries of unknown sources, an injury should be classified as injury of unknown source when both of the following conditions are met: 1. The source of the injury was not observed by any person or the source of the injury could not be explained by the resident AND 2. The injury is suspicious because the extent of the injury or the location of the injury or the number of injuries observed at one particular point in time or the incident of injuries over time (multiple bruising, repeat bruising)...." This federal tag relates to Complaint IN00087056. 3.1-28(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING _____ B. WING _____	03/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN46617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0312 SS=E	Based on observations, interviews and record reviews, the facility failed to provide grooming needs, especially nail care for 1 resident in the sample of 6 and for 9 residents in the supplemental sample who were unable to carry out these activities of daily living. These residents resided in 2 of 4 nursing units. Residents: C,H, I, J, K, L, M, N, O and P. Findings include: During interviews and orientation tour on 3/7/11 between 10:00 a.m. and 11:00 a.m., the following residents,C,H,I,J,K,L,M,N,O and P were observed to have either long, jagged or dirty fingernails. The Unit Managers #1 and 2 identified the residents as dependent on the nursing staff to provide care. 1. Review of the clinical record on 3/8/10 at 10:30 a.m., for Resident C indicated the diagnoses included, but were not limited to confusion and dementia. The quarterly Minimum Data Set (MDS) assessment, dated 12/15/10, indicated the resident required the extensive assistance of one person for maintaining personal hygiene. The plan of care, dated 5/20/10, identified a problem of the resident requiring limited to extensive assist with	F0312	F 312 It is the practice of this provider that residents who are unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal, and oral hygiene. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** · Resident # C: The resident has received ADL care including nail care per the Plan of Care. · Resident # H: The resident has received ADL care including nail care per the Plan of Care. · Resident # I: The resident has received ADL care including nail care per the Plan of Care. · Resident # J: The resident has received ADL care including nail care per the Plan of Care. · Resident # K: The resident has received ADL care including nail care per the Plan of Care. · Resident # L: The resident has received ADL care including nail care per the Plan of Care. · Resident # M: The resident has received ADL care including nail care per the Plan of Care. · Resident # N: The resident has received ADL care including nail care per the Plan of Care. · Resident # O: The resident has received ADL care including nail	04/07/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING _____ B. WING _____	03/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN46617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	all ADLs (activities of daily living). 2. Review of the clinical record on 3/7/11 at 11:00 a.m., for Resident H indicated the diagnoses included, but were not limited to Alzheimer's dementia and macular degeneration. The admission MDS assessment, dated 10/21/10, indicated the resident was totally dependent on staff for personal hygiene. 3. Review of the clinical record on 3/7/11 at 10:10 a.m., for Resident I indicated the diagnoses included, but were not limited to CVA (cerebral vascular accident) and diabetes. The plan of care, dated 12/2/10, indicated a self care deficit and decreased functional ability and the resident required assistance with ADLs due to impaired cognition. 4. Review of the clinical record on 3/7/11 at 10:28 a.m., for Resident J indicated the diagnoses included, but were not limited to dementia and legal blindness. The plan of care, dated 2/23/10, identified a need for limited to extensive assist with ADLs due to the diagnosis of dementia. 5. Review of the clinical record on 3/7/11 at 10:30 a.m., for Resident K indicated the diagnoses included, but were not limited to left hemiparesis and depression. The		care per the Plan of Care. · Resident # P: The resident has received ADL care including nail care per the Plan of Care. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** · Residents who reside in the facility have the potential to be affected by the alleged deficient practice. · Licensed nurses, Qualified Medication Aides, and Certified Nursing Assistants were re-educated to providing ADL care by the Director of Nursing Services, and/or designee, on 03/31/11, and ongoing, as needed. · Noncompliance with facility policy and procedure may result in employee re-education, and/or disciplinary action up to and including termination. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur** · Licensed nurses, Qualified Medication Aides, and Certified Nursing Assistants were re-educated to providing ADL care by the Director of Nursing Services, and/or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING _____ B. WING _____	03/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN46617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	annual MDS assessment, dated 12/28/10, indicated the resident required the extensive of one person for maintaining personal hygiene. 6. Review of the clinical record on 3/7/11 at 10:35 a.m., for Resident L indicated the diagnoses included, but were not limited to anoxic brain damage and convulsions. The plan of care dated 4/1/10, indicated the resident was in need of total assistance with ADLs related to his comatose state. 7. Review of the clinical record on 3/7/11 at 10:40 a.m., for Resident M indicated the diagnoses included, but were not limited to dementia and osteoporosis. The annual MDS assessment, dated 10/12/10, indicated the resident required the extensive assistance of one person for maintaining personal hygiene. 8. Review of the clinical record on 3/7/11 at 10:45 a.m., for Resident N indicated the diagnoses included, but were not limited to blindness and hypertension. The quarterly MDS assessment, dated 10/21/10, indicated the resident was totally dependent on staff for personal hygiene. 9. Review of the clinical record on 3/7/11 at 10:38 a.m., for Resident O indicated the		designee, on 03/31/11, and ongoing, as needed. · The Director of Nursing Services is responsible to monitor for facility compliance in providing necessary care and services to the residents. · Charge nurses will make care rounds at least 2 times a shift to observe for quality resident grooming. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** · A Resident Care Rounds CQI tool will be utilized weekly x 4, monthly x 4, and then quarterly, to monitor compliance with necessary care and services. The governing CQI committee will review the data. If the threshold for compliance is not met, an action plan will be developed. **What is the date by which the systemic changes will be completed** **Compliance Date: April 7, 2011**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING _____ B. WING _____	03/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN46617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	diagnoses included, but were not limited to anxiety with behavioral disturbances and confusion. The plan of care, dated 3/1/11, identified a need for limited to extensive assist with ADLs due to the diagnosis of dementia. 10. Review of the clinical record on 3/7/11 at 10:50 a.m., for Resident P indicated the diagnoses included, but were not limited to paranoid schizophrenia and quadriparesis due to spinal stenosis. The significant change MDS assessment, dated 9/30/10, indicated the resident was totally dependent on staff for personal hygiene. During interviews on 3/7/11 at 10:30 a.m. and 10:55 a.m., respectively with Unit Managers #1 and #2, the Unit Managers indicated the residents' nails should have been cut and cleaned on a daily basis and if the residents did refuse, the staff should have tried at a different time. This federal tag relates to Complaint IN00087056. 3.1-38(a)(3)(E)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING _____ B. WING _____	03/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN46617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING _____ B. WING _____	03/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN46617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0323 SS=D	Based on observation, interviews and record reviews, the facility failed to ensure a resident, identified by the facility as cognitively impaired, received adequate supervision to prevent the resident from wandering around in the facility without the staff's knowledge. The resident was found during the middle of the night in the locked dietary area. This deficient practice affected 1 of 1 residents reviewed for wandering in the sample of 6. Resident: C Findings include: During orientation tour on 3/7/11 at 10:05 a.m., Resident C was observed seated in a wheelchair in the hall. A clip alarm was attached to the resident's wheelchair. Review of the clinical record on 3/8/11 at 10:30 a.m., indicated the resident's diagnoses included, but were not limited to confusion, dementia, depression, pacemaker insertion and glaucoma. The significant change minimum data set (MDS) assessment, dated 9/14/10, indicated the resident had short term memory impairment, periods of restlessness and did wander. She required assistance in all areas of activities of daily	F0323	F 323 It is the practice of this provider to ensure that the facility ensures that the residents environment remains free of accident hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents. **What corrective action(s) will be** accomplished for those residents **found to have been affected by the deficient practice** · Resident #C is provided supervision to ensure staff have knowledge of residents whereabouts at all times and she had a wander guard placed · The dietary door had a new lock installed. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** · Residents residing in the facility have the potential to be affected by the alleged deficient practice. · Nursing staff were re-educated on the supervision of residents 3/8/11 & 3/31/11 and ongoing. · Dietary staff were re-educated on environmental procedures	04/07/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING _____ B. WING _____	03/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN46617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	living. The resident's primary mode of transportation was the wheelchair. Review of a reportable incident provided by the Administrator on 3/8/11, indicated the resident was found in the facility kitchen during the night shift hours on 3/6/11 at approximately 2:30 a.m., by the nursing staff. The resident was found sitting in her wheelchair with unopened mayonnaise packets on her lap and asking for "chicken, I'm hungry." The resident was unable to recall why or how she went into the kitchen. During interview with the Administrator on 3/8/11 at 2:35 p.m., she indicated she had spoken to the evening nurse, who last saw the resident between 8:00-8:30 p.m., and the 2-10 shift CNAS indicated they last observed the resident between 8:15 p.m. and 8:20 p.m. The Administrator further indicated the night shift CNAS (10:00 p.m. to 6:00 a.m.) indicated they did not do a bed check on the resident at the beginning of their shift. The Administrator indicated CNA#4 went to make rounds at around 1:00 a.m., and realized the resident was not in her room. The nursing staff then began a facility room to room search between 1:00 a.m. and 2:00 a.m. They heard the resident in the kitchen and then called the		regarding locking the kitchen 3/8/11 & 3/31/11. · Noncompliance with facility policy and procedure may result in employee disciplinary action up to and including termination. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur** · Residents at risk for wandering were identified and care plans have been reviewed and revised, as needed. · Residents with assistance devices are monitored by licensed nurses and nursing assistants for presence and function no less than each shift and with resident contact. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** · A CQI tool will be utilized weekly x 4, monthly x 2 and quarterly, to monitor compliance with supervision and assistance devices to prevent accidents. The governing CQI committee will review the data. If the threshold for compliance is not met, an action plan will be developed. **What is the date by which the**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING _____ B. WING _____	03/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN46617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	maintenance supervisor to unlock the door, which had locked when the resident entered the area. The Administrator indicated the doors to the dietary department automatically locked when the staff left the kitchen and at the end of the shift the night cook was responsible was responsible for locking the doors from the inside. Interview on 3/9/11 at 1:45 p.m., with the evening cook indicated she locked the door that night and was unsure of how the resident got into the kitchen. Interview on 3/9/11 at 1:45 p.m. with the Maintenance Supervisor indicated they had never had any problems with the doors locking prior to this incident. He indicated the locks have been changed as of 3/8/11. 3.1-45(a)(2)		**systemic changes will be completed** **Compliance Date: April 7, 2011**	